DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING _____ B. WING _____	01/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for a Recertification and State Licensure Survey. Survey dates: January 10, 11, 12, and 14, 2011 Facility Number: 010739 Provider Number: 155764 Aim Number: N/A Survey Team: Sheila Sizemore, RN, TC Marcia Mital, RN Kelly Sizemore, RN Regina Sanders, RN (January 11, 12, and 14, 2011) Census bed type: SNF: 37 Residential: 57 Total: 94 Census Payor Type: Medicare: 30 Other: 64 Total: 94 Sample: 10 Supplemental sample: 5 Residential Sample: 7 Supplemental Residential Sample: 1 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed 1-19-11 Cathy Emswiller RN	F 000	Survey Event ID: 8SXV11 The submission of this Plan of Correction does not indicate an admission by Spring Mill Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Spring Mill Health Campus. This facility recognized it's obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	F 157		

RECEIVED
FEB - 4 2011
LONG TERM CARE DIVISION
INDIANA STATE DEPARTMENT OF HEALTH

Approved 2/3/11 SW

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marvin Davisson — TITLE: Executive Director — (X6) DATE: 2/2/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

ORIGINAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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AH
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 155764	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 1/14/2011

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 441	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to transport linens to prevent the spread of infection, related to 2 of 2 linen cart covers which were cracked and torn on 1 of 2 units (Healthcare 2). This had the potential to affect 23 residents who resident Healthcare 2.

Findings include:

During the environmental tour with the Maintenance Director on 01/12/11 at 3 p.m. through 3:30 p.m., there were two linen carts stored in the, "Spa Room". The covers of both carts were cracked and had small tears.

During an interview at the time of the observation, the Maintenance Director acknowledged the linen cart covers were cracked.

3.1-19(g)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

F-441 Infection Control

1. Facility infection control manual reviewed and no negative outcomes were noted.
2. All residents had potential to be affected. Reviewed facility infection control manual and no negative outcomes were noted.
3. Linen carts and covers were replaced.
4. The Director of Plant Operations or designee will audit the linen carts and covers as part of the preventative maintenance program. QA Committee will review trends monthly.
5. February 13, 2011

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F 157	Continued From page 1 A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure residents' physician's were notified of medication refusal and an elevated blood sugar for 2 of 10 residents reviewed for	F 157	F-157 Physician Notification 1. Resident #22 and #87 had their physicians notified at the time of survey. They have been evaluated by their physicians and no negative outcomes noted. 2. Current residents MAR's will be reviewed for the past 60 days. The facility guidelines will be followed for any findings requiring notification. 3. The licensed staff will be in serviced on the facility guidelines of physician notification. The diabetic books and the MAR's will be reviewed by the Unit Manager at least 5 days a week for any findings requiring notification. 4. The DHS or designee will review the Medication Administration Record (MAR)'s, diabetic records, and the 24 hour report at least 5 days per week until 100% compliance is obtained for 3 weeks, then at least 2 days per week as part of the ongoing QA process. Results will be reviewed by the facility QA Committee.	2/13/11

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F 157	Continued From page 2 notification of physicians in a sample of 10. (Resident's #22 and #87) Findings include: 1. Resident #22's record was reviewed on 1/12/11 at 9:55 a.m. Resident #22's diagnoses included, but were not limited to diabetes mellitus, cancer, anemia, and dementia. The physician's order recapitulation, dated 1/11, indicated to check the resident's blood sugars twice a day and to call the physician if the resident's blood sugar was greater than 400. The resident's diabetic monitoring flow record, indicated the resident's blood sugar on 1/3/11 at 4:00 p.m., was 429. The form indicated the physician was not notified of the blood sugar. The nurses' notes for the above date, lacked documentation to indicate the physician had been notified of the resident's 429 blood sugar. During an interview on 1/12/11 at 10:45 a.m., LPN #1 indicated the physician should have been notified of the resident's blood sugar over 400. 2. Resident #87's closed record was reviewed on 1/12/11 at 12:10 p.m. Resident #87's diagnoses included, but were not limited to, stage 4 renal carcinoma, dementia, and cerebral vascular accident (CVA) (stroke). A physician's order, dated 10/05/10, indicated Heparin (blood thinner) 5,000 units twice a day. A November 2010, Medication Administration Record, indicated Resident #87 had refused the dinner time dose of the Heparin medication on	F 157		

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F 157	Continued From page 3 November 4, 5, 6, 7, 8, and 9, 2010. There was a lack of documentation in the resident's record of the physician being notified of the resident's refusal of the dinner time dose of the Heparin medication. During an interview on 1/12/11 at 5:20 p.m., the DoN indicated Resident #87's physician had not been notified of the resident's refusal of the Heparin medication at dinner time. A facility policy, dated 12/06/07, titled "Physician Notification Guidelines," indicated "To ensure the resident's physician is aware of all diagnostic testing results or changes in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care...." 3.1-5(a)(1)	F 157		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a resident had been assessed and determined to be safe to administer her own medication related to, a resident administering a nebulizer treatment (breathing treatment) independently for 1 resident of 10 residents reviewed for medications in a sample of 10. (Resident #3)	F 176	F-176 SELF Administration of Drugs 1. The assessment was completed on resident # 3 at the time of survey. The resident was evaluated and no negative effects were noted. 2. Current residents utilizing hand held nebulizers have been evaluated regarding their ability to administer their own drugs via this method of delivery. Family and physicians will be notified of any results indicating they are unable to utilize the hand held nebulizer.	

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F 176	Continued From page 4 Findings include: Resident #3 was observed sitting up in her wheelchair on 1/11/11 at 9:05 a.m., in her room. Resident #3 was observed to turn on her nebulizer machine and place the mouthpiece in her mouth and begin her breathing treatment. There were no staff present during the above time in the resident's room. Resident #3's record was reviewed on 1/10/11 at 12:00 p.m. Resident #3's diagnoses included, but were not limited to, congestive heart failure, congenital mitral insufficiency, pleural effusion, dementia, and edema. A physician's order, dated 12/04/10, indicated "Albuterol (a medication to improve breathing) .083%...tx (treatment) every 8 hours for sob (shortness of breath)." Review of the resident's record lacked documentation of a self administration of medication assessment or a physician's order to self administer medications. A quarterly MDS (Minimum Data Set) assessment, dated 12/31/10, indicated Resident #3's cognitive (mental) status was moderately impaired. During an interview on 1/11/11 at 9:10 a.m., in the hallway with LPN #2, she indicated the resident did not have a self administration of medication assessment. LPN #2 indicated she had put the medication for the breathing treatment in the mouthpiece earlier so the resident could do her treatment.	F 176	F-176 Continued 3. Licensed staff will be in serviced on the criteria and the process of self administration assessments with hand held nebulizers. 4. The DHS or designee will review all new admits and/or new orders for administration of nebulizer treatments by a hand held nebulizer as part of the ongoing QA process.	2/13/11

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F 176	Continued From page 5 During an interview on 1/11/11 at 9:11 a.m., the Nurse Consultant indicated the resident needed a self administration of medication assessment. The Nurse Consultant indicated LPN #2 had placed the medication in the cup. Resident #3 was observed on 1/11/11 at 9:14 a.m., still continuing her breathing treatment in her room. There were no staff present in the resident's room. During an interview on 1/11/11 at 10:35 a.m., the Healthcare Unit Manager indicated she had just completed a self administration of medication assessment on Resident #3. A facility policy, dated 3/1/07, titled "Self-Administration of Medications" indicated "Residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility...." 3.1-11(a)	F 176		
F 272 SS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information;	F 272	F-272 Comprehensive Assessments 1. The comprehensive assessments on residents #3, 5, 27, and 29 cannot be corrected since they are in the past. The residents were evaluated and no negative outcome noted. The CAA was completed on resident #18 at the time of survey.	

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F 272	Continued From page 6 Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure assessments were complete and accurate related to skin conditions, vital signs, alarms, and CAA (Care Area Assessment), for 5 of 10 resident's reviewed for complete and accurate assessments in a sample of 10. (Residents #3, #5, #18, 27, and #29) Findings include: 1. Resident #18's record was reviewed on 1/11/11 at 9:30 a.m. Resident #18's diagnoses included, but were not limited to, fractured right shoulder, dementia, and depression. Resident #18's admission MDS (minimum data	F 272	F-272 Continued 2. All residents have the potential to be effected by the alleged deficient practice relating to the daily skilled assessments. The MDS coordinators will review the last 90 days of MDS's with CAA's for appropriate summary related to the assessment. 3. The licensed staff will be in-serviced on the appropriate completion of the daily skilled nursing assessment. The MDS coordinators have been in serviced on the CAA process. 4. The DHS or designee will review the daily skilled charting for completeness in particular the safety, skin, and vital signs at least 5 days a week. CAA's will be reviewed when completed until 100% compliance is achieved for 3 weeks, then at twice weekly for 6 months. Thereafter, it will be part of the ongoing QA monitoring process quarterly.	2/13/11

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F 272	Continued From page 7 set) assessment, with an assessment reference date of 12/1/10, indicated the Care Area Assessment Summary triggered for psychotropic drug use. The CAA Summary indicated to "see attached summary" for psychotropic drug use. There was a lack of documentation of a summary for psychotropic drug use. During an interview on 1/11/11 at 11:10 a.m., MDS coordinator #1 indicated there should have been a completed CAA summary for psychotropic drug use for the resident. 2. Resident #29's record was reviewed on 1/10/11 at 12:10 p.m. Resident #29's diagnoses included, but were not limited to, dementia, osteoarthritis, and hypertension. A pressure ulcer assessment form, indicated the resident had a suspected deep tissue injury upon admission on 12/6/10 on her right heel. The form indicated the following: 12/8/10 the pressure ulcer was a stage IV (full thickness loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed). 12/15/10 the pressure ulcer was a stage IV. 12/22/10 the pressure ulcer was a stage IV. 12/29/10 the pressure ulcer was a stage IV. 1/5/11 the pressure ulcer was a stage IV. The resident's skilled nursing assessments, dated 12/12/10 at 10:15 a.m., 12/14/10 at 9 a.m., 12/15/10 at 9:15 a.m., 12/16/10 at 9:30 a.m., 12/17/10 at 10 a.m., 12/18/10 at 9 a.m., 12/19/10 at 9:30 a.m., 12/20/10 at 10 a.m., 12/24/10 at 10:30 a.m., 12/25/10 at 3 p.m., 12/26/10 at 9:30 a.m., 12/28/10 no time documented, 12/29/10 at	F 272		

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F 272	Continued From page 8 8 a.m., 12/30/10 at 12:30 p.m., and 1/2/11 at 12:15 p.m. all indicated the resident had no skin impairment. During an interview on 1/10/11 at 1:30 p.m., the LPN unit manager indicated the assessments were not correct because the resident had skin impairment. 3. Resident #3's record was reviewed on 1/10/11 at 12:00 p.m. Resident #3's diagnoses included, but were not limited to, congestive heart failure, congenital mitral insufficiency, pleural effusion, dementia, and edema. A Skilled Nursing Assessment and Data Collection form, dated 12/16/10, indicated all of the sections were left blank. A Skilled Nursing Assessment and Data Collection form, dated 12/24/10, lacked documentation of the type of pulse and the site. A Skilled Nursing Assessment and Data Collection form, dated 12/25/10, lacked documentation of the resident's vital signs. A Skilled Nursing Assessment and Data Collection form, dated 12/28/10, lacked documentation of the type of pulse and the site. A Skilled Nursing Assessment and Data Collection form, dated 12/30/10, lacked documentation of the type of pulse and the site. A Skilled Nursing Assessment and Data Collection form, dated 1/04/11, lacked documentation of the type of pulse and the site.	F 272		

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F 272	Continued From page 9 During an interview on 1/10/11 at 12:44 p.m., the Nurse Consultant indicated "the vitals are pertinent to the assessment and should be filled out. 4. Resident #5's record was reviewed on 1/11/11 at 10:05 a.m. Resident #5's diagnoses included, but were not limited to, Alzheimer's Disease, difficulty in walking, and osteoporosis. Skilled Nursing Assessment and Data Collection forms, dated December 26, 27, 29, 30, 31, 2010 and January 1, 2, and 4, 2011, lacked documentation of the type of alarm the resident had in place. During an interview on 1/11/11 at 10:45 a.m., the Healthcare Unit Manager indicated the assessment should be completed. 5. Resident #27's record was reviewed on 1/11/11 at 10:37 a.m. Resident #27's diagnoses included, but were not limited to, congestive heart failure, hypertension, and benign prostatic hypertrophy (enlarged prostate). Resident #27's original admission date was 10/19/10. A Pressure/Stasis/Arterial/Diabetic Ulcer Assessment, dated 10/20/10, indicated the resident had a pressure area on the meatus and was present on admission. Skilled Nursing Assessment and Data Collection forms indicated the resident did not have any skin impairments on the following dates: 10/19/10 3-11 shift 10/20/10 at 5:40 a.m. 10/21/10 at 3:30 a.m.	F 272		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 10 During an interview with LPN #1, on 1/12/11 at 12:15 p.m., she indicated the skin assessments were not correct.	F 272		
F 278 SS=E	3.1-31(a) 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 278	F-278 Assessment Accuracy 1. The MDS's on residents # 3,8,18, and 22 were corrected at the time of the survey. 2. The MDS's of the current residents will be reviewed for accuracy and appropriate corrections made as indicated. 3. The MDS coordinators have been in-serviced on MDS accuracy. 4. The DHS or designee will review MDS's upon completion for accuracy until 95% accuracy is achieved for 3 months. MDS's will be reviewed by the home office support team at least quarterly for accuracy as part of the ongoing QA process.	2/13/11

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F 278	Continued From page 11 Based on record review and interview, the facility failed to ensure MDS (Minimum Data Set) Assessments were completed accurately, related to missed diagnoses, a pressure ulcer, and an influenza vaccine for 4 of 10 residents reviewed for accuracy of MDS's in a sample of 10. (Residents #3, #8, #18, #22) Findings include: 1. Resident #8's record was reviewed on 1/10/11 at 12:05 p.m. Resident #8's diagnoses included, but were not limited to, multiple sclerosis, hypertension, anxiety, and depression. A Physician's Order, dated 12/6/10, indicated add diagnoses of depression and anxiety. A Quarterly MDS Assessment, dated 12/24/10, lacked documentation for the diagnoses, depression and anxiety. During an interview with MDS Coordinator #2, on 1/11/11 at 10:10 a.m., she indicated anxiety and depression should have been checked on the MDS. 2. Resident #3's record was reviewed on 1/10/11 at 12 p.m. Resident #3's diagnoses included, but were not limited to, congestive heart failure, congenital mitral insufficiency, edema, pleural effusion, and dementia. A Physician's Recapitulation Order, dated 1/1/11 through 1/31/11, indicated a diagnosis of dementia. A Quarterly MDS Assessment, dated 1/4/11, lacked documentation for the diagnosis of	F 278		

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F 278	Continued From page 12 dementia. During an interview with MDS Coordinator #2, on 1/11/11 at 9:37 a.m., she indicated dementia should have been checked on the MDS. 3. Resident #18's record was reviewed on 1/11/11 at 9:30 a.m. Resident #18's diagnoses included, but were not limited to, fractured right shoulder, dementia, and depression. Resident #18's admission MDS (minimum data set) assessment, with an assessment reference date of 12/1/10, indicated the resident had a stage IV (full thickness loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed) pressure ulcer which was 4.5 centimeters by 4.5 centimeters. The most severe tissue type of any pressure ulcer was marked epithelial tissue-new skin growing in superficial ulcer. The resident's pressure ulcer assessment form, indicated the resident had a pressure ulcer on his right heel. On 12/1/10 the pressure ulcer was a stage IV, 4.5 by 4.5 centimeters and was 90% black (eschar or necrotic tissue {dead tissue}). During an interview on 1/11/11 at 1:50 p.m., the Healthcare Unit Manager indicated the MDS was not coded correctly for the most severe tissue type. 4. Resident #22's record was reviewed on 1/12/11 at 9:55 a.m. Resident #22's diagnoses included, but were not limited to diabetes mellitus, cancer, anemia, and dementia. The resident's influenza immunization education and informed consent, dated 11/3/10, indicated	F 278		

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F 278	Continued From page 13 the resident had already received the immunization prior to admission. The resident admission physician's orders, dated 11/3/10, indicated an order for Prilosec for gastroesophageal reflux disease (GERD). Resident #22's admission MDS assessment, with an assessment reference date of 11/10/10, indicated, under active diagnoses, GERD was not checked. The MDS indicated the resident had received the influenza immunization at the facility. During an interview on 1/12/11 at 10:33 a.m., MDS coordinator #2 indicated GERD was not marked on the MDS and the resident had not received the influenza immunization at the facility. 3.1-31(g)	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to meet professional standards of quality, related to a nurse (LPN #7) borrowing medications from 1 resident to administer to another resident for 1 (Resident #8) of 10 residents reviewed for medications in a sample of 10 residents and during the observation of the medication pass there were 3 errors in medication administration were observed during 42 opportunities for error in medication administration. This resulted in a	F 281	F-281 Professional Standards 1. The residents #8 and #88 have been evaluated and no negative outcomes were noted from the alleged deficient practice. LPN#7 received a coaching and counseling regarding borrowing medication. 2. All residents have the potential to be effected by the alleged deficient practice.	

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F 281	Continued From page 14 medication error rate of 7.14% for 1 resident in a supplemental sample of 5. (Resident #88) Findings include: 1. During the second medication pass on 1/12/11 at 4:10 p.m., LPN #9 was observed to notice the dosage of Resident #8's coumadin (blood thinner) was incorrect. The medication punch card held 13 tablets of the 4 mg (milligrams) dosages instead of the 3 mg. Resident #8's physician's order on the January 2011 MAR (Medication Administration Record) indicated "coumadin 3 mg 1 tab (tablet) p.o. (by mouth) qd (everyday)." LPN #9 indicated she would need to obtain the correct dosage of coumadin from the pyxis station (emergency drug machine). LPN #9 was observed to obtain a 1 mg tablet and a 2 mg tablet from the pyxis station for the resident. The January 2011, MAR was initialed from 1/6/11 through 1/11/11, indicating the 3 mg of coumadin had been administered as ordered by the physician. During an interview on 1/12/11 at 5:00 p.m., the ADoN, indicated the pharmacy had stated Resident #8 had not received any coumadin from the pyxis station in December or January. During an interview on 1/12/11 at 5:10 p.m., The Healthcare Unit Manager indicated she did not have an answer if the resident had received 4 mg or 3 mg of coumadin for the six days. During an interview on 1/12/11 at 5:15 p.m., The DoN indicated she was not aware if the resident had gotten the 3 mg of coumadin as ordered. The DoN indicated "guess not."	F 281	F-281 Continued 3. The licensed staff have been in- serviced on the campus policy on "no borrowing" of medications and the crushing of medications. 4. The DHS or designee will conduct medication pass review with 100% of the licensed staff and appropriate education or coaching and counseling initiated based on the results. Repeat reviews will be conducted until 100% compliance is achieved. Random medication pass observations will be completed at least monthly for 3 months, thereafter, then quarterly based on the outcomes and the QA Committee recommendations.	2/13/11

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F 281	Continued From page 15 Resident #8's record was reviewed on 1/12/11 at 5:15 p.m. Resident #8's diagnoses included, but were not limited to, multiple sclerosis and history of deep vein thrombosis. A physician's order dated 1/5/11, indicated "1. Hold 4 mg Coumadin today. 2. D/C (discontinue) 4 mg Coumadin. 3. Coumadin 3 mg p.o. qd. 4. Recheck q (every) 1 week. (sic)." During an interview on 1/12/11 at 5:15 p.m., LPN #7 indicated she had borrowed 6 mg Coumadin tablets from another resident and "cut" them in half to administer the 3 mg to the resident. LPN #7 indicated she had done this twice on 1/7 and 1/9. LPN #7 indicated she did not know why she did not obtain the medication from the pyxis station. During interview on 1/12/11 at 5:50 p.m., the Healthcare Unit Manager indicated she could not determine what resident the medication had been obtained from. A facility policy, titled "Medication Administration-General Guidelines," dated 3/1/07, indicated "...Medications supplied for one resident are never administered to another resident..." 2. During the medication pass there were 3 errors in medication administration were observed during 42 opportunities for error in medication administration. This resulted in a medication error rate of 7.14%. During the medication pass observation on 1/12/11 at 9:18 a.m. through 9:25 a.m., LPN #7 was observed preparing medication for resident	F 281		

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F 281	Continued From page 16 #88. LPN #7 crushed the tablets of Prilosec (stomach medication) 20 milligrams and potassium chloride (supplement) 20 milliequivalents. LPN #7 opened the capsule of Cardizem CD (cardiac medication)180 milligrams and placed them in yogurt and then administered the medications to the resident. During an interview on 1/12/11 at 9:35 a.m., LPN #7 indicated she needed a physician's order to crush medication. She indicated she did not have a do not crush list for medications on her medication cart. Resident #88's record was reviewed on 1/12/11 at 9:28 a.m. Resident #88's diagnoses included, but were not limited to, gastrointestinal bleed and congestive heart failure. The resident's admission physician's orders, dated 1/11/11, lacked documentation of an order to crush the resident's medications. A "medications not to be crushed" list, provided by LPN #1 on 1/12/11 as current, indicated potassium chloride and Cardizem CD were not to be crushed due to time release formulations. The Nursing Spectrum Drug Handbook, dated 2010 indicated: Cardizem CD (extended release capsule), pages 351-353, indicated "Patient teaching *Instruct patient to swallow extended-release-capsules whole and not to crush or chew them..." Prilosec, pages 857-858, indicated "Patient teaching...*Instruct patient to swallow capsules or tablets whole and not to chew or crush them..." During an interview on 1/12/11 at 9:38 a.m., LPN	F 281		

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F 281	Continued From page 17 #1 indicated the potassium chloride and Prilosec should not have been crushed. She indicated the Cardizem CD extended release capsule should not have been opened. 3.1-35(g)(2)	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure physician's orders and resident's plans of care were followed, related to a treatment to prevent pressure ulcers and fall interventions, for 6 of 10 resident's reviewed for following physician's orders and plans of care in a sample of 10. (Residents #3, #5, #8, #22, #27, and #29) Findings include: 1. Resident #27's record was reviewed on 1/11/11 at 10:37 a.m. Resident #27's diagnoses included, but were not limited to, congestive heart failure, hypertension, and benign prostatic hypertrophy (enlarged prostate). Resident #27's original admission date was 10/19/10. Admission orders, dated 10/19/10, indicated to apply granulex (topical medication to prevent pressure ulcers) to left heel daily to prevent breakdown.	F 282	F-282 Following Care Plans 1. Residents #3, #5, #8, #22, #27, and #29 were evaluated at the time of survey and no negative outcomes were noted. Medication error circumstance reports were completed and the nurses involved received coaching and counseling. 2. Current resident's care plans will be reviewed for interventions in particular in regards to safety and skin to ensure they are on the CRCA assignment sheet and implemented. 3. The staff will be in serviced on the interventions to prevent falls, skin maintenance, and medication administration.	

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F 282	Continued From page 18 A MAR (Medication Administration Record), dated 10/1/10 through 10/31/10, indicated apply granulex to left heel daily to prevent breakdown. The following dates, 10/20, 10/22, 10/23, 10/24, 10/25, and 10/26, were initialed and circled indicating the medication was unavailable. The record lacked documentation as to why the medication was not available. During an interview with LPN #1, on 1/12/11 at 11 a.m., she indicated "I wrote granulex to be delivered on 10/21, because I contacted the pharmacy. I don't know why it wasn't here for those days." 2. During the initial tour on 1/10/11 beginning at 10:05 a.m. Resident #5 was observed sitting up in her wheelchair in the dining room. The resident's tab alarm was connected to the wheelchair and the clip to the alarm was laying on her sweater. CNA #5 who was standing by the resident, indicated the clip was not connected to the resident's sweater. Resident #5 was observed sitting up in her wheelchair on 1/11/11 at 9:12 a.m., in the dining room. The clip to the resident's alarm was hanging down the back of the wheelchair and not clipped to the resident. CNA #6, who was in the dining room indicated the clip was supposed to be clipped to the resident. Resident #5's record was reviewed on 1/11/11 at 10:05 a.m. Resident #5's diagnoses included, but were not limited to, Alzheimer's Disease, difficulty in walking, and osteoporosis. A care plan for at risk for falls, dated 12/06/10,	F 282	F-282 Continued 4. The DHS or designee will monitor care plan interventions in regards to skin and safety at least daily until 100% compliance is achieved for 3 weeks then at least twice weekly for 3 months and then no less than quarterly. The DHS or designee will conduct medication pass review with 100% of the licensed staff and appropriate education or coaching and counseling initiated based on the results. Then repeat reviews will be conducted until 100% compliance is achieved. Random medication pass observations will be completed at least monthly for 3 months, thereafter, then quarterly based on the outcomes and the QA Committee recommendations.	2/13/11

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F 282	Continued From page 19 indicated "...personal alarm to chair." 3. Resident #29's record was reviewed on 1/10/11 at 12:10 p.m. Resident #29's diagnoses included, but were not limited to, dementia, osteoarthritis, and hypertension. Resident #29's care plan, dated 12/14/10, indicated the resident was at risk for falls. The interventions included, but were not limited to, "appropriate footwear." Resident #29 was observed on 1/10/11 at 12:23 p.m., 12:56 p.m., and 1:39 p.m., sitting in the second floor dining room with socks on without any shoes. During an interview on 1/10/11 at 1:40 p.m., the Healthcare Unit Manager indicated the resident was not wearing any shoes. She indicated the resident's fall care plan indicated the resident was to wear appropriate footwear. 4. Resident #22's record was reviewed on 1/12/11 at 9:55 a.m. Resident #22's diagnoses included, but were not limited to diabetes mellitus, bone cancer, anemia, and dementia. A hospital physician's order, dated 11/3/10, indicated "dexamethasone (a medication which stimulates bone marrow and reduces inflammation) 4 mg (milligrams)...Take 40 mg by mouth daily...x (times) 4 days po (orally)...every 28 days. Instructions: Finished cycle Nov (November) 3rd start December 1st." The resident's admission physician's orders, dated 11/3/10, indicated dexamethasone 4 mg -take 40 mg every day times four days. the medication was due to be administered on	F 282		

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F 282	Continued From page 20 12/1/10. The resident's MAR (Medication Administration Record), dated 12/10, indicated the resident received the dexamethasone as ordered on 12/1/10, 12/2/10, 12/3/10, and 12/4/10. The resident's MAR, dated 1/11, indicated dexamethasone ten 4 mg tablets were to be administered on 1/1/11, 1/2/11, 1/3/11 and 1/4/11. There was a lack of documentation to indicate the medication was to be administered on 1/4/11. Observation of a medication punch card on 1/12/10, indicated the card had 40 four milligram tablets in it when the pharmacy had delivered the medication. There were 33 tablets left in the card. During an interview on 1/12/11 at 11:10 a.m., LPN #7 indicated the pharmacy had sent 80 tablets of the dexamethasone in November. During an interview on 1/12/10 at 11:30 a.m., LPN #7 indicated she did not know why there were 33 tablets of dexamethasone left if the medication had been given as ordered. The Nursing Spectrum Drug Handbook, dated 2010, pages 331-333, indicated "dexamethasone...Patient teaching...caution patient not to stop taking drug abruptly..." A "Medication error circumstance investigation, dated 1/12/11, received from the Healthcare Unit Manager indicated the date of the error 1/1/11-1/4/11. The wrong dose was administered. 5. Resident #3's record was reviewed on 1/10/11	F 282		

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F 282	Continued From page 21 at 12 p.m. Resident #3's diagnoses included, but were not limited to, congestive heart failure, arthritis, and hypertension. Resident #3's physician's order recapitulation, dated 1/11, indicated the resident had an allergy to Tramadol (pain medication). A physician's order, dated 1/4/11, indicated "Tramadol 50 mg (milligrams) every 6 o (hours) as needed for pain." The resident's MAR, dated 1/11, indicated the resident had received the Tramadol on 1/7/10. During an interview on 1/10/11 at 12:30 p.m., the DoN (Director of Nurses) indicated the nurses should be checking for allergies before giving medications. During an interview on 1/10/11 at 12:35 p.m., the Nurse Consultant indicated the pharmacy should have caught the allergy and called the facility. She indicated the nurses should have caught the allergy also. 6. During the second medication pass on 1/12/11 at 4:10 p.m., LPN #9 was observed to notice the dosage of Resident #8's coumadin (blood thinner) was incorrect. The medication punch card held 13 tablets of the 4 mg (milligrams) dosages instead of the 3 mg. Resident #8's physician's order on the January 2011 MAR (Medication Administration Record) indicated "coumadin 3 mg 1 tab (tablet) p.o. (by mouth) qd (everyday)." LPN #9 indicated she would need to obtain the correct dosage of coumadin from the pyxis station (emergency drug machine). LPN #9 was observed to obtain a 1 mg tablet and a 2 mg	F 282		

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	155764	A. BUILDING _____ B. WING _____	01/14/2011

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F 282	Continued From page 22 tablet from the pyxis station for the resident. The January 2011, MAR was initialed from 1/6/11 through 1/11/11, indicating the 3 mg of coumadin had been administered as ordered by the physician. At on 1/12/11 at 5:00 p.m., the ADoN, indicated the pharmacy had stated Resident #8 had not received any coumadin from the pyxis station in December or January. The Healthcare Unit Manager, indicated at 5:10 p.m., she did not have an answer if the resident had received 4 mg or 3 mg of coumadin for the six days. The DoN at 5:15 p.m., indicated she was not aware if the resident had gotten the 3 mg of coumadin as ordered. The DoN indicated "guess not." Resident #8's record was reviewed on 1/12/11 at 5:15 p.m. Resident #8's diagnoses included, but were not limited to, multiple sclerosis and history of deep vein thrombosis. A physician orders recapitulation, dated January 2011, indicated "Coagucheck (test for blood clotting) every Wednesday, keep between 2-3 notify MD (doctor) if <2 or >3." A resident coag testing record indicted the resident's level was 3.5 on 1/5/11 and on 1/12/11 was 1.8 A physician's order dated 1/5/11, indicated "1. Hold 4 mg Coumadin today. 2. D/C (discontinue) 4 mg Coumadin. 3. Coumadin 3 mg p.o. qd. 4.	F 282		

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F 282	Continued From page 23 Recheck q (every) 1 week. (sic)." A physician's telephone order, dated 12/17/10 indicated the resident was to start 4 mg of Coumadin every day. Observation on 1/12/11 at 4:10 p.m., of a medication punch card, indicated it was received from the pharmacy on 12/17/10. The medication card contained 30 tablets of Coumadin 4 milligrams. There were still 13 tablets left in the punch card. The resident's MAR, dated 12/10, indicated the Coumadin 4 milligram tablets had been administered on 12/17/10 though 12/31/10 (15 tablets of medication should have been administered.). The resident's MAR. dated 1/11, indicated the Coumadin 4 milligram tablets had been administered on 1/1/11- 1/4/11 (4 tablets should have been administered). This is a total of 19 tablets which should have been administered to the resident. There should have been 11 tablets left of the Coumadin 4 milligrams in the medication punch card, not 13 tablets. During an interview on 1/12/11 at 5:15 p.m., LPN #7 indicated she had borrowed 6 mg Coumadin tablets from another resident and "cut" them in half to administer the 3 mg to the resident. LPN #7 indicated she had done this twice on 1/7 and 1/9. LPN #7 indicated she did not know why she did not obtain the medication from the pyxis station.	F 282		

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F 282	Continued From page 24 During interview on 1/12/11 at 5:50 p.m., the Healthcare Unit Manager indicated she could not determine what resident the medication had been obtained from. During an interview on 1/12/11 at 7:08 p.m., the ADoN indicated the facility pharmacy had stated the pharmacy had never received the order for the 3 mg Coumadin and needed to have the order faxed to the pharmacy. 3.1-35(g)(2)	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide the necessary care and services related to failure to monitor a resident with a diagnosis of congestive heart failure and a resident with a diagnosis of end stage renal disease, who were both on fluid restrictions for 2 of 2 residents with fluid restrictions in a sample of 10. (Residents #3 and #11) Findings include: 1. Resident #3 was observed during the initial tour	F 309	F-309 Provide Services to Achieve Highest Standard of Care 1. Alleged deficiencies were corrected at the time of survey for residents #3 and #11. Both residents have been evaluated and no negative outcomes were noted. 2. Current residents with fluid restrictions will be evaluated and corrections to their monitoring made as appropriate. Physician's orders will be compared to menu cards for all current residents. Updates will be made as necessary. 3. The campus has implemented a flow sheet to monitor fluid intake with the nurses MAR. This process will be in-serviced with nursing staff.	

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F 309	Continued From page 25 on 1/10/11 beginning at 10:05 a.m., with LPN #2. The resident was observed sitting up in her wheelchair in her room. There were two plastic cups sitting on the bedside table, one cup was empty and the other was half full. The plastic cups held 120 cc (cubic centimeters). LPN #2 indicated the resident's weight was stable. Resident #3 was observed on 1/10/11 at 1:05 p.m., sitting up in her wheelchair in her room with her lunch tray. The tray had an eight ounce (240 cc) glass of water on it. The resident's menu card indicated 66 cc per shift and the resident was on a 1400 cc fluid restriction. The menu card indicated 1/2 cup (120 cc)of juice and 1/2 cup (120) of coffee. At 1:16 p.m., the resident had a coffee cup (240) filled with coffee, the DoN indicated the resident usually only drinks a half a cup of the coffee. The DoN indicated she did not know why the 66 cc was on the resident's menu card. At 1:20 p.m., the dietary manager indicated the resident had received too much fluid from dietary on her tray. At 1:24 p.m., the DoN indicated she did not know if the resident was on intake and output record (I & Os). At 1:33 p.m., the Nurse Consultant indicated intake and output were not done at the facility unless the resident "was on an IV (intervenous medication) or something." At 1:35 p.m., the RD (Registered Dietician) indicated "We need to scrap this and start all over." The Nurse Consultant agreed.	F 309	F-309 Continued 4. The DHS or designee will review the fluid intake flow sheets at least 5 days per week until 100% compliance is achieved for 3 weeks then at least twice per week for 3 months and then quarterly with the ongoing QA process. The Director of Dining Services or designee will review menu tickets to physician's orders monthly and review trends in monthly QA meeting.	2/13/11

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F 309	Continued From page 26 Resident #3's record was reviewed on 1/10/11 at 12:00 p.m. Resident #3's diagnoses included, but were not limited to, congestive heart failure, congenital mitral insufficiency, pleural effusion, dementia, and edema. A physician's order, dated 12/12/10, indicated "1400 cc fluid restriction, 400 cc per shift, 66 cc allowed for food." A nutrition assessment, dated 12/03/10, indicated "NAS (no added salt) 1400 cc FR (fluid restriction) (400 cc/nursing per shift & 66 cc per meal)...." A facility meal and fluid detail report for December 2010, lacked documentation of the fluid intake for the following meals, on these dates: Breakfast: 11, 12, 15, 16, 20, 24, and 26. Lunch: 9, 11, 15, 16, 17, 18, 19, 20, 24, 26, 27, 29, and 30. Dinner: 6, 7, 10, 13, 14, 16, 20, and 28. A facility meal and fluid detail report for January 2011, lacked documentation of the fluid intake for the following meals, on these dates: Breakfast: 1, 7, 8, and 9. Lunch: 1, 3, 6, 7, 8, 9, and 10. Dinner: 2, 3, 4, 8, and 10. During an interview on 1/12/11 at 11:30 a.m., the DoN indicated the staff had done good tracking the fluid intake in December but not January. A January 2011, MAR (Medication Administration Record) indicated the nurses were initialing the resident was receiving 400 cc per shift.	F 309		

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F 309	Continued From page 27 A care plan for "potential for/alteration in nutritional and/or fluid balance status'" dated 12/14/10 and revised 1/4/11 indicated "...consult rd for decline in food/fluid intake...." A care plan, dated 11/11/10, for dehydration, indicated "Monitor weight as ordered and report gain/loss to MD (medical doctor)...Provide fresh water at bedside...." A care plan, dated 12/13/10, for at risk for decreased cardiac output indicated "...fluid restriction as ordered." The DoN indicated on 1/12/11 at 10:20 a.m., the nurses keep track of the resident's fluids on their shift by writing notes and telling the oncoming shift if the resident stays in her fluid restriction. The DoN indicated the nurses then sign the MAR. 2. Resident #11's record was reviewed on 1/12/11 at 9:05 a.m. Resident #11's diagnoses included, but were not limited to, end stage renal disease, dialysis, and hypertension. A physician's order, dated 12/15/10, indicated "1200 ml (milliliters) fluid restriction." A January 2011 MAR, indicated "1200 ml fluid restriction." The facility nurses were initialing the resident was receiving 1200 ml fluids per day. A 1/12/11 dietary card, indicated the resident was on a 1000 cc fluid restriction. A nutrition assessment, dated 12/20/10, indicated "...1000 ml fld (fluid restriction)...." The nutrition assessment form was checked to monitor p.o. (by mouth) intake, wt (weight) and labs.	F 309		

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F 309	Continued From page 28 A dietary progress note, dated 12/20/10, indicated "...reflecting of renal dx (diagnosis) decrease (arrow pointing down) na+ (sodium) no diuretic tx (treatment) possibly r/t (related to) excess fluid r/t being a dialysis pt (patient)...." A care plan, dated 12/23/10, indicated the resident was non-compliant with the fluid restriction. A facility meal and fluid detail report for December 2010, lacked documentation of the fluid intake for the following meals on these dates: Breakfast: 8, 10, 12, 15, 16, 17, 20, 24, 27, 29, 30, and 31. Lunch: 8, 9, 11, 15, 16, 17, 20, 22, 24, 26, and 29. Dinner: 7, 8, 10, 13, 14, 16, 20, 22, 24, and 28. A facility meal and fluid detail report for January 2011, lacked documentation of the fluid intake for the following meals on these dates: Breakfast: 1, 3, 5, 7, 8, 9, and 10. Lunch: 1, 3, 5, 6, 7, 8, 9, and 10. Dinner: 2, 4, and 8. A facility policy, dated 7/08, titled "Guidelines For Fluid Restriction," indicated "to ensure fluids are provided within the physician order guidelines...3. the Dietary Department shall record established breakdown by meal on tray card. 4. The Nursing Department shall record established breakdown by shift on the Medication Administration Record and/or in the Care Tracker system. 5. Record intake of fluid on the Care Tracker system Measurements Program. 6. Fluid consumption shall be reviewed each shift to determine adjustments necessary in the fluid intake of the	F 309		

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F 309	Continued From page 29 resident on the restriction in order to meet their established fluid needs...." 3.1-37(a)	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a preventative treatment was done as order to prevent pressure ulcers for 1 of 10 residents at risk for developing pressure ulcers in a sample of 10 residents. (Resident #27) Finding include: 1. Resident #27's record was reviewed on 1/11/11 at 10:37 a.m. Resident #27's diagnoses included, but were not limited to, congestive heart failure, hypertension, and benign prostatic hypertrophy (enlarged prostate). Resident #27's original admission date was 10/19/10. A care plan, dated 10/22/10, indicated potential for alteration in skin integrity, the interventions included, but were not limited to, administer	F 314	F-314 Pressure Ulcers 1. Resident #27 never had pressure ulcer to his left heel. The Granulex treatment has been discontinued. 2. The current residents will be audited for similar orders and ensure the appropriate preventive measures are in place and available. 3. The licensed staff will be in-serviced on the appropriate interventions for prevention of pressure ulcers. 4. The DHS or designee will monitor the Treatment Administration Record's (TAR)'s at least 5 days per week until 100% compliance is achieved and then twice per week for 3 months and then quarterly as part of the ongoing QA process.	2/13/11

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F 314	Continued From page 30 preventative treatments. Admission orders, dated 10/19/10, indicated to apply granulex (topical medication to prevent pressure ulcers) to left heel daily to prevent breakdown. A MAR (Medication Administration Record), dated 10/1/10 through 10/31/10, indicated apply granulex to left heel daily to prevent breakdown. The following dates, 10/20, 10/22, 10/23, 10/24, 10/25, and 10/26, were initialed and circled indicating the medication was unavailable. The record lacked documentation as to why the medication was not available. During an observation, on 1/12/11 at 9:22 a.m., resident #27's heels did not have any open areas. During an interview with LPN #1, on 1/12/11 at 11 a.m., she indicated "I wrote granulex to be delivered on 10/21, because I contacted the pharmacy. I don't know why it wasn't here for those days."	F 314		
F 332 SS=D	3.1-40(a)(1) 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a medication	F 332	F-332 Medication Error Resident #88 was evaluated at the time of the survey and no negative outcomes were noted.	

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F 332	Continued From page 31 error rate of less than 5% for 1 of 5 supplemental sample residents (Resident #88) observed receiving medications. 3 errors in medication administration were observed during 42 opportunities for error in medication administration. This resulted in a medication error rate of 7.14%. Findings include: 1. During the medication pass observation on 1/12/11 at 9:18 a.m. through 9:25 a.m., LPN #7 was observed preparing medication for resident #88. LPN #7 crushed the tablets of Prilosec (stomach medication) 20 milligrams and potassium chloride (supplement) 20 milliequivalents. LPN #7 opened the capsule of Cardizem CD (cardiac medication)180 milligrams and placed them in yogurt and then administered the medications to the resident. During an interview on 1/12/11 at 9:35 a.m., LPN #7 indicated she needed a physician's order to crush medication. She indicated she did not have a do not crush list for medications on her medication cart. Resident #88's record was reviewed on 1/12/11 at 9:28 a.m. Resident #88's diagnoses included, but were not limited to, gastrointestinal bleed and congestive heart failure. The resident's admission physician's orders, dated 1/11/11, lacked documentation of an order to crush the resident's medications. A "medications not to be crushed" list, provided by LPN #1 on 1/12/11 as current, indicated potassium chloride and Cardizem CD were not to	F 332	F-332 Continued 2. All residents have the potential to be affected by the alleged deficient practice. 3. The licensed staff will be in-serviced on the professional standards of medication administration with emphasis on medication crushing and the appropriate way to obtain and administer medications. 4. The DHS or designee will conduct medication pass review with 100% of the licensed staff and appropriate education or coaching and counseling initiated based on the results. Then repeat reviews will be conducted until 100% compliance is achieved. Random medication pass observations will be completed at least monthly for 3 months thereafter, then quarterly based on the outcomes and the QA Committee recommendations.	2/13/11

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F 332	Continued From page 32 be crushed due to time release formulations. The Nursing Spectrum Drug Handbook, dated 2010 indicated: Cardizem CD (extended release capsule), pages 351-353, indicated "Patient teaching *Instruct patient to swallow extended-release-capsules whole and not to crush or chew them..." Prilosec, pages 857-858, indicated "Patient teaching...*Instruct patient to swallow capsules or tablets whole and not to chew or crush them..." During an interview on 1/12/11 at 9:38 a.m., LPN #1 indicated the potassium chloride and Prilosec should not have been crushed. She indicated the Cardizem CD extended release capsule should not have been opened. 3.1-25(b)(9)	F 332		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure residents' were free of significant medication errors for 3 of 10 residents reviewed for significant medication errors in a sample of 10 residents. (Residents #3, #8, and #22) Findings include: 1. Resident #22's record was reviewed on 1/12/11 at 9:55 a.m. Resident #22's diagnoses	F 333	F-333 Significant Med Error 1. Residents #22, #3, and #8 were evaluated at the time of survey with no indication of negative outcomes. 2. All residents have the potential to be affected by the alleged deficient practice.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

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F 333	Continued From page 33 included, but were not limited to diabetes mellitus, bone cancer, anemia, and dementia. A hospital physician's order, dated 11/3/10, indicated "dexamethasone (a medication which stimulates bone marrow and reduces inflammation) 4 mg (milligrams)...Take 40 mg by mouth daily...x (times) 4 days po (orally)...every 28 days. Instructions: Finished cycle Nov (November) 3rd start December 1st." The resident's admission physician's orders, dated 11/3/10, indicated dexamethasone 4 mg -take 40 mg every day times four days. the medication was due to be administered on 12/1/10. The resident's MAR (Medication Administration Record), dated 12/10, indicated the resident received the dexamethasone as ordered on 12/1/10, 12/2/10, 12/3/10, and 12/4/10. The resident's MAR, dated 1/11, indicated dexamethasone ten 4 mg tablets were to be administered on 1/1/11, 1/2/11, 1/3/11 and 1/4/11. There was a lack of documentation to indicate the medication was to be administered on 1/4/11. Observation of a medication punch card on 1/12/10, indicated the card had 40 four milligram tablets in it when the pharmacy had delivered the medication. There were 33 tablets left in the card. During an interview on 1/12/11 at 11:10 a.m., LPN #7 indicated the pharmacy had sent 80 tablets of the dexamethasone in November. During an interview on 1/12/10 at 11:30 a.m.,	F 333	F-333 Continued 3. The licensed staff will be in-serviced on the professional standards of medication administration with emphasis on medication crushing and the appropriate way to obtain and administer medications. 4. The DHS or designee will conduct medication pass review with 100% of the licensed staff and appropriate education or coaching and counseling initiated based on the results. Then repeat reviews will be conducted until 100% compliance is achieved. Random medication pass observations will be completed at least monthly for 3 months thereafter, then quarterly based on the outcomes and the QA Committee recommendations.	2/13/11

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F 333	Continued From page 34 LPN #7 indicated she did not know why there were 33 tablets of dexamethasone left if the medication had been given as ordered. The Nursing Spectrum Drug Handbook, dated 2010, pages 331-333, indicated "dexamethasone...Patient teaching...caution patient not to stop taking drug abruptly..." A "Medication error circumstance investigation, dated 1/12/11, received from the Healthcare Unit Manager indicated the date of the error 1/1/11-1/4/11. The wrong dose was administered. 2. Resident #3's record was reviewed on 1/10/11 at 12 p.m. Resident #3's diagnoses included, but were not limited to, congestive heart failure, arthritis, and hypertension. Resident #3's physician's order recapitulation, dated 1/11, indicated the resident had an allergy to Tramadol (pain medication). A physician's order, dated 1/4/11, indicated "Tramadol 50 mg (milligrams) every 6 o (hours) as needed for pain." The resident's MAR, dated 1/11, indicated the resident had received the Tramadol on 1/7/10. During an interview on 1/10/11 at 12:30 p.m., the DoN (Director of Nurses) indicated the nurses should be checking for allergies before giving medications. During an interview on 1/10/11 at 12:35 p.m., the Nurse Consultant indicated the pharmacy should have caught the allergy and called the facility. She indicated the nurses should have caught the	F 333		

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F 333	Continued From page 35 allergy also. 3. During the second medication pass on 1/12/11 at 4:10 p.m., LPN #9 was observed to notice the dosage of Resident #8's coumadin (blood thinner) was incorrect. The medication punch card held 13 tablets of the 4 mg (milligrams) dosages instead of the 3 mg. Resident #8's physician's order on the January 2011 MAR (Medication Administration Record) indicated "coumadin 3 mg 1 tab (tablet) p.o. (by mouth) qd (everyday)." LPN #9 indicated she would need to obtain the correct dosage of coumadin from the pyxis station (emergency drug machine). LPN #9 was observed to obtain a 1 mg tablet and a 2 mg tablet from the pyxis station for the resident. The January 2011, MAR was initialed from 1/6/11 through 1/11/11, indicating the 3 mg of coumadin had been administered as ordered by the physician. At on 1/12/11 at 5:00 p.m., the ADoN, indicated the pharmacy had stated Resident #8 had not received any coumadin from the pyxis station in December or January. The Healthcare Unit Manager, indicated at 5:10 p.m., she did not have an answer if the resident had received 4 mg or 3 mg of coumadin for the six days. The DoN at 5:15 p.m., indicated she was not aware if the resident had gotten the 3 mg of coumadin as ordered. The DoN indicated "guess not." Resident #8's record was reviewed on 1/12/11 at 5:15 p.m. Resident #8's diagnoses included, but were not limited to, multiple sclerosis and history	F 333		

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F 333	Continued From page 36 of deep vein thrombosis. A physician orders recapitulation, dated January 2011, indicated "Coagucheck (test for blood clotting) every Wednesday, keep between 2-3 notify MD (doctor) if <2 or >3." A resident coag testing record indicted the resident's level was 3.5 on 1/5/11 and on 1/12/11 was 1.8 A physician's order dated 1/5/11, indicated "1. Hold 4 mg Coumadin today. 2. D/C (discontinue) 4 mg Coumadin. 3. Coumadin 3 mg p.o. qd. 4. Recheck q (every) 1 week. (sic)." A physician's telephone order, dated 12/17/10 indicated the resident was to start 4 mg of Coumadin every day. Observation on 1/12/11 at 4:10 p.m., of a medication punch card, indicated it was received from the pharmacy on 12/17/10. The medication card contained 30 tablets of Coumadin 4 milligrams. There were still 13 tablets left in the punch card. The resident's MAR, dated 12/10, indicated the Coumadin 4 milligram tablets had been administered on 12/17/10 though 12/31/10 (15 tablets of medication should have been administered.). The resident's MAR. dated 1/11, indicated the Coumadin 4 milligram tablets had been administered on 1/1/11- 1/4/11 (4 tablets should have been administered). This is a total of 19 tablets which should have	F 333		

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F 333	Continued From page 37 been administered to the resident. There should have been 11 tablets left of the Coumadin 4 milligrams in the medication punch card, not 13 tablets. During an interview on 1/12/11 at 5:15 p.m., LPN #7 indicated she had borrowed 6 mg Coumadin tablets from another resident and "cut" them in half to administer the 3 mg to the resident. LPN #7 indicated she had done this twice on 1/7 and 1/9. LPN #7 indicated she did not know why she did not obtain the medication from the pyxis station. During interview on 1/12/11 at 5:50 p.m., the Healthcare Unit Manager indicated she could not determine what resident the medication had been obtained from. During an interview on 1/12/11 at 7:08 p.m., the ADoN indicated the facility pharmacy had stated the pharmacy had never received the order for the 3 mg Coumadin and needed to have the order faxed to the pharmacy. 3.1-25(b)(9) 3.1-48(c)(2)	F 333		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services	F 425	F-425 Pharmaceutical Services 1. The Granulex was delivered to the building on October 21, 2010.	

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F 425	Continued From page 38 (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure medications were accurately received from pharmacy, related to a resident not receiving a topical medication as ordered for 6 days, for 1 of 10 residents reviewed for receiving medications in a sample of 10. (Resident #27) Findings include: 1. Resident #27's record was reviewed on 1/11/11 at 10:37 a.m. Resident #27's diagnoses included, but were not limited to, congestive heart failure, hypertension, and benign prostatic hypertrophy (enlarged prostate). Resident #27's original admission date was 10/19/10. Admission orders, dated 10/19/10, indicated to apply granulex (topical medication to prevent pressure ulcers) to left heel daily. A MAR (Medication Administration Record), dated 10/1/10 through 10/31/10, indicated apply granulex to left heel daily. The following dates, 10/20, 10/22, 10/23, 10/24, 10/25, and 10/26,	F 425	F-425 Continued 2. All residents have the potential to be affected by the alleged deficient practice. 3. The licensed staff will be in-serviced on the appropriate way of ordering and obtaining drugs. 4. The DHS or designee will audit the MAR's and drug delivery sheets until 100% compliance is achieved then quarterly as part of the facility QA.	2/13/11

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F 425	Continued From page 39 were initialed and circled indicating the medication was unavailable. The record lacked documentation as to why the medication was not available. A facility policy, dated 3/1/07, received as current,Executive Director, titled, "Medication Ordering and Receiving from Pharmacy," indicated "Procedures...3. New medications...are ordered as follows:...a. If needed before the next regular delivery, phone the medication order to the pharmacy immediately upon receipt. b. Timely delivery of new orders is required so that medication administration is not delayed...B. Receiving Medications from the Pharmacy 1) A licensed nurse:...c. Promptly reports discrepancies and omissions to the issuing pharmacy and the charge nurse/supervisor..." During an interview with LPN #1, on 1/12/11 at 11 a.m., she indicated "I wrote granulex to be delivered on 10/21, because I contacted the pharmacy. I don't know why it wasn't here for those days"	F 425		
F 460 SS=E	3.1-25(a) 483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.	F 460	F-460 Bedrooms assure full visual privacy 1. Privacy curtains in rooms 2216-bed A, 2212-bed A and B, 2210-bed A and B, 2208-bed A, 2205 bed A and B, 2202-bed A, and 1100 bed A and B were replaced the evening of the environmental tour.	

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F 460	Continued From page 40 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide privacy for 11 of 14 residents, related to gaps in the resident's privacy curtains for 7 of 7 resident rooms(Rooms 1100 bed A and B, 2202 bed A, 2205 bed A and B, 2208 bed Bed A, 2210 bed A and B, 2212 bed A and B, and 2216 bed A) on 2 of 2 units. (Healthcare 1 and Healthcare 2) Findings include: During the environmental tour with the Maintenance Director on 01/12/11 at 3 p.m. through 3:30 p.m., room 2216-bed A, 2212-bed A and B, 2210- bed A and B, room 2208- bed A, room 2205- bed A and B, 2202-bed A, and 1100-bed A and B, had an approximate three foot gap in the resident's privacy curtains. During an interview at the time of the observation, the Maintenance Director indicated the gaps were about three feet. He indicated they put the short curtains on the long curtain track. 3.1-19(l)(6) 3.1-19(l)(7)	F 460	F-460 Continued 2. All residents had potential to be affected. Grievance/Service Recovery Report and Resident Council minutes reviewed with no noted complaints regarding privacy. 3. All available privacy curtains were put up in facility rooms on evening of the environmental tour in place of any that had a three foot gap. Additional privacy curtains were ordered. 4. Director of Environmental Services or Designee will check privacy curtains weekly with housekeeping room audit. Trends will be reviewed monthly at QA Meeting.	2/13/11
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514	F-514 Clinical Records 1. Resident #30, #11, #18, and #88 records were corrected at the time of survey.	

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F 514	Continued From page 41 The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure resident's clinical records were complete and accurate, related to inaccurate diagnoses for medications, discontinuing a sliding scale, incorrect fluid restriction on dietary card, and incomplete name of a medication, for 3 of 10 residents in a sample of 10 (Residents #11, #18, #30) and 1 of 5 residents in a supplemental sample of 5 (Resident #88), reviewed for complete and accurate clinical records. Findings include: 1. Resident #30's record was reviewed on 1/12/11 at 9:35 a.m. Resident #30's diagnoses included, but were not limited to, Alzheimer's Disease, peripheral vascular disease, diabetes mellitus, and osteoarthritis. A physician's order, dated 10/8/10, indicated to discontinue accu checks (blood sugar checks). A Physician's Recapitulation Order, dated 1/1/11 through 1/31/11, indicated "Humulin R (regular insulin)100 units per milliliter...SSI (sliding scale insulin): 150-200= 2 units; 2201-250= 4 units..." During an interview with LPN #1, on 1/12/11 at 10:45 a.m., she indicated "The order for the	F 514	F-514 Continued 2. Current resident's records will be reviewed for appropriate diagnosis and accuracy of recapitulations and admission orders. The family and physician will be notified of any discrepancies and appropriate corrections made. 3. The licensed staff will be in-serviced on receiving and transcribing orders. New admission orders will be reviewed in the morning clinical meeting 5 days per week. 4. The DHS or designee will monitor the recaps and new admission orders at least 5 days per week until 100 % compliance is achieved. Thereafter, at least 20 charts per month will be audited for accuracy of recaps and the new admits will be reviewed in the morning meeting 5 days per week.	2/13/11

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F 514	Continued From page 42 sliding scale should not be on the recap because we are not doing accu checks anymore." 2. Resident #18's record was reviewed on 1/11/11 at 9:30 a.m. Resident #18's diagnoses included, but were not limited to, fractured right shoulder, dementia, and depression. The physician's order recapitulation, dated 1/11, indicated orders for aspirin (used to prevent heart conditions) for hypertension, Synthroid (medication for hypothyroidism) for hyperlipidemia, and Zocor (medication for hyperlipidemia) for depression. During an interview on 1/11/11 at 11 a.m., the Healthcare Unit Manager indicated the diagnoses for the above medications were not correct. 3. Resident #88's record was reviewed on 1/12/11 at 9:28 a.m. Resident #88's diagnoses included, but were not limited to, gastrointestinal bleed and congestive heart failure. The resident's hospital transfer orders, dated 1/10/11, indicated Cardizem (medication for congestive heart failure) CD (extended release) 180 milligrams daily. The resident's admission physician's orders, dated 1/10/11, indicated "Cardizem 180 mg..." There was a lack of documentation of the CD on the order for the Cardizem. During an interview on 1/12/11 at 9:38 a.m., LPN #1 indicated the medication name had not been transcribed completely on the physician's admission orders. 4. Resident #11's record was reviewed on	F 514		

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F 514	Continued From page 43 1/12/11 at 9:05 a.m. Resident #11's diagnoses included, but were not limited to, ESRD (end stage renal disease), hypertension, and arthritis. A) The resident's physician's order recapitulation, dated 1/11, indicated the resident was taking aspirin for hypertension, Plavix (a blood thinner) for congestive heart failure, and Zocor for hypertension. During an interview on 1/12/11 at 10:20 a.m., the DoN indicated the diagnoses were not correct for the medications. B) The resident's physician's order recapitulation, dated 1/11, indicated the resident was on a 1200 milliliter fluid restriction. The resident's dietary card indicated the resident was on a 1000 cc (cubic centimeter) fluid restriction. During an interview on 1/12/11 at 10:55 a.m., the dietary manager indicated she would fix the resident's dietary card. 3.1-50(a)(1) 3.1-50(a)(2)	F 514		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING _____ B. WING _____	01/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

LONG TERM CARE DIVISION
INDIANA STATE DEPARTMENT OF HEALTH

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS The following State Residential findings are in accordance with 410 IAC 16.2-5.	R 000		
R 036	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights-Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. This RULE is not met as evidenced by: Based on record review and interview, the facility failed to notify residents' physician's related to medications not given as ordered, high blood sugars, and a skin condition for 3 of 7 residents reviewed for physician notification in a sample of 7. (residents #46, #64, and #81) Findings include: 1) Resident #81's record was reviewed on 01/12/11 at 9:35 a.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease and prostate cancer. The resident's physician's recapitulation orders, dated 12/10, indicated an order, dated 04/16/10, for CL-7 (herbal supplement), three tablets at bedtime daily. A Medication Administration Record (MAR), dated 11/10, indicated the CL-7 was not given as	R 036	R-036 Resident Rights 1. Residents #81, #46 and #64 had their physicians notified at the time of survey. They have been evaluated with no negative outcomes noted. 2. Current residents MAR's will be reviewed for the past 30 days. The facility guidelines will be followed for any findings requiring notification. 3. The licensed staff will be in-serviced on the facility guidelines of physician notification. The diabetic books and the MAR's will be reviewed by the Unit Manager or designee at least 5 days a week for any findings requiring notification. 4. The DHS or designee will review the MAR's and diabetic records at least 5 days per week until 100% compliance is obtained for 3 weeks, then at least 2 days per week as part of the ongoing QA process. Results will be reviewed by the facility QA Committee.	02/21/11

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R 036	Continued From page 1 ordered on 11/08/10 through 11/30/10 due to the medication was unavailable. A MAR, dated 12/10, indicated the CL-7 was not given as ordered by the physician on 12/01/10, 12/02/10, 12/04/10, 12/11/10, and 12/12/10, as ordered by the physician due to the medication was unavailable. There was a lack of documentation the resident's physician was aware the CL-7 had not been given and was unavailable from 11/01/10 through 12/13/10. During an interview on 01/12/11 at 10:10 a.m., the Residential Unit Manager indicated the physician had not been notified of the resident not getting the medication until 12/13/10. She indicated the physician should have been notified earlier than 12/13/10. 2. Resident #46's record was reviewed on 01/11/11 at 1:45 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and Alzheimer's Disease. The physician's recapitulation orders, dated 01/11, indicated an order received 09/29/10 for accu-checks (blood sugar monitoring) to be completed daily at 6 a.m. and 4 p.m.. The order indicated the resident's physician was to be notified for blood sugars over 400. The MAR, dated 12/10, indicated the resident's blood sugar on 12/25/10 at 4 p.m. was 424, and 10 units of insulin was given. There was a lack of documentation on the 12/10 MAR and in the resident's record to indicate the resident's physician had been notified of the	R 036		

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R 036	Continued From page 2 blood sugar over 400. During an interview on 01/12/11 at 9:10 a.m., the Residential Unit Manager indicated the resident's physician had not been notified of the blood sugar over 400 on 12/25/10. 3. Resident #64's record was reviewed on 01/12/11 at 10:25 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease and osteoarthritis. A physician's order, dated 12/15/10, indicated the resident had an abscessed lesion on the top of her right foot. The order indicated to apply Silvadene Cream (topical antibiotic) and a dressing daily for 10 days and then notify the physician of the healing progress. The resident's nurses' notes lacked documentation to indicate the resident's physician had been notified as ordered, of the status of the area after the 10 days of treatment. During an interview on 01/12/11 at 10:50 a.m., the Residential Unit Manager indicated the physician had not been notified as ordered.	R 036		
R 144	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. This RULE is not met as evidenced by: Based on observation and interview, the facility failed to ensure the facility was clean and in good repair related to chipped paint on heaters, scratched chairs and missing veneer on a table, a	R 144	R-144 Sanitation and Safety Standards 1. Room 110 and 114 had heaters repainted at the time of the survey. The table veneer will be replaced. All chairs in the dining room will be repaired. The hole in the back of the cabinet was patched at the time of the survey. Juice streaks on the front of the cabinets in the main dining room were cleaned at the time of survey. The liquid butter on the pub lounge cabinet and dirt on the shelves were cleaned.	

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R 144	Continued From page 3 hole in a cabinet, which had the potential to affect 10 of 10 residents who reside on the Memory Care Unit, and juice stains on the outside of the cabinet in the main dining room and and a dirty cabinet in the pub lounge, which had the potential to affect 47 of 47 residents who live in the Residential Unit. Findings include: During the environmental tour on 01/12/11 at 2:26 p.m. through 3 p.m. with the Maintenance Director, the following was observed: 1. Memory Care Unit: Room 110 and 114 had numerous paint chips on the front of the heaters in the resident's rooms. During an interview at the time of the observation, the Maintenance Director indicated he checks the resident's rooms weekly. One of four tables in the dining room had the veneer off of the side of the table. 17 of 18 chairs in the dining room were scratched and scraped. During an interview at the time of the observation, the Maintenance Director indicated the chairs get scraped from the table. There was a hole in the back of the cabinet in the resident lounge 2. There were juice streaks on the front of the cabinets in the main dining room. 3. A cabinet in the pub lounge had spilled liquid butter and dirt on the shelves. During an interview at the time of the observation, the Maintenance Director indicated Housekeeping or the Activities	R 144	R 144 Continued 2. All residents have the potential to be effected by the alleged deficient practice. All rooms were inspected and heaters upgraded as needed. All cabinets have been checked for needed repairs. All cabinets have been cleaned. There were no negative outcomes noted during the time of these inspections. 3. The Director of Plant Operations (DPO) will be in-serviced on checking heaters, tables, chairs & cabinets routinely. Environmental services staff will be in-serviced on routine cleaning of cabinets and shelves. 4. The DPO or designee will check heaters, chairs & tables 2 x's per week as part of preventative maintenance rounds. Director of Environmental Services (DES) will monitor cleanliness of shelves and cabinets daily until 100% achieved. After compliance is achieved DPO & DES will monitor all areas weekly. Trends will be reported at the monthly QA meeting.	02/21/11

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R 144	Continued From page 4 department were suppose to clean the area.	R 144		
R 148	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. This RULE is not met as evidenced by: Based on observation and interview, the facility failed to ensure the building was free of hazards, related to an accumulation of lint build up in 2 of 2 hair dryers in 1 of 1 Beauty Shop. This has the potential to affect 57 of 57 residents who live in the residential facility. Findings include: During the environmental tour on 01/12/11 at 2:25 p.m. through 3 p.m. with the Maintenance Director, the Beauty Shop was closed. There was an accumulation of lint in two of two hair dryers in the Beauty Shop. During an interview at the time of the observation,	R 148	R-148 Sanitation and Safety Standards 1. The lint in the beauty shop was cleaned at the time of the survey. 2. All residents who visit the beauty shop have the potential to be effected by the alleged deficient practice. There were no negative outcomes noted. 3. Environmental services staff and beauticians will be in-serviced on the process of cleaning the hair dryers routinely. 4. The DES or designee will check the Beauty Shop weekly for proper cleaning of the hair dryers. Trends will be reported monthly at the QA meeting.	02/21/11

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R 148	Continued From page 5 the Maintenance Director indicated the Beautician cleans the Beauty Shop.	R 148		
R 154	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. This RULE is not met as evidenced by: Based on observation and interview, the facility failed to keep kitchen areas clean related to dirty refrigerators/freezers for 2 of 3 refrigerators in resident lounges (Memory Care Unit and the Pub Lounge). This had the potential to affect 10 of 10 residents who reside in the Memory Care Unit and 47 of 47 residents who reside in the residential facility. Findings include: During the environmental tour on 01/12/11 at 2:25 p.m. through 3 p.m. with the Maintenance Director, the following was observed: 1. There was a spilled brown substance, and a sticky substance spilled in the freezer in the Memory Care Unit. The seal around the freezer door was dirty and had a brown crusty substance on the seal. During an interview at the time of the observation, the Maintenance Director indicated the CNA's were suppose to clean the freezer. 2. There was an accumulation of ice in the freezer of the Pub Lounge freezer. There was a pink substance spilled in the refrigerator. During an interview at the time of the observation, the	R 154	R-154 Sanitation and Safety Standards 1. The freezer and the door in the Memory Care Unit was cleaned at the time of the survey. The Pub freezer and refrigerator were cleaned at the time of the survey. 2. All residents have the potential to be effected by the alleged deficient practice. There were no negative outcomes noted. 3. The environmental services staff will be in-serviced on cleanliness procedures related to freezers and refrigerators. 4. The DES or designee will conduct daily rounds of freezer and refrigerators until 100% compliance is achieved. After compliance is achieved DES will conduct weekly rounds. Trends will be reported at the monthly QA meeting.	02/21/11

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R 154	Continued From page 6 Maintenance Director indicated either housekeeping or activities were suppose to clean the area.	R 154		
R 241	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. This RULE is not met as evidenced by: Based on record review and interview, the facility failed to ensure physicians' orders were followed, related to medications not held as ordered, medications not given as ordered, dietary supplements not discontinued as ordered, treatments not completed as ordered and the physician was not notified as ordered for 4 of 7 residents reviewed for following physicians' orders in a sample of 7. (Residents #46, #64, #68, and #81) Findings include: 1. Resident #68's record was reviewed on 01/12/11 at 11:35 a.m. The resident's diagnoses included, but were not limited to, dementia and stroke. The resident's recapitulation physician's orders, dated 12/10, indicated the resident had an order, dated 02/15/10, for aspirin 81 milligrams chew tab, one tablet daily. A hospital, "History and Physical", dated 12/23/10, indicated, "...sent here from the	R 241	R-241 Health Services 1. Residents #68, #64, #46, and #81 were evaluated at the time of survey and no negative outcomes were noted. Physicians were notified per guidelines. 2. All residents have the potential to be effected by the alleged deficient practice. Current residents' MAR's will be reviewed for the last 30 days. Orders will be followed accordingly and physician's notified per guidelines. 3. All licensed staff will be in-serviced on following physician orders and physician notification. 4. The Unit Manager or designee will review the MAR's at least 5 times weekly until 100% compliance is obtained for 3 weeks, then 2 times per week as part of the ongoing QA process.	02/21/11

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R 241	Continued From page 7 assisted living due to coffee-ground emesis x (times) 2 this morning, also hemoccult-positive (test for blood) from the ED (Emergency Department)...Staff at the assisted living noted that the emesis appeared coffee-ground and was brought here by family...She was admitted under 23 hour observation..." A hospital, "Discharge Summary", dated 12/24/10, indicated a diagnoses of positive occult blood with possible gastrointestinal bleed. The hospital return orders, dated 12/24/10, indicated, "...no...aspirin...until okay with (physician's name)..." There was a lack of documentation in the resident's record to indicate the resident went to the hospital, returned from the hospital, and the resident's physician had been notified of the order to hold the aspirin. The Medication Administration Record (MAR), dated 12/10, indicated the resident received the aspirin daily on 12/25/10 through 12/31/10. The MAR, dated 01/11, indicated the resident received the aspirin daily on 01/01/11 through 01/11/11. During an interview on 01/11/11 at 11 a.m., Residential LPN #1, indicated he had not seen the order to hold the aspirin. He indicated he thought the family took the resident to the emergency room. During an interview on 01/11/11 at 11:10 a.m., the Residential Unit Manager indicated she did not recall the resident going to the hospital. She indicated the aspirin was not held as ordered by	R 241		

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R 241	Continued From page 8 the physician. She indicated the physician had not been notified of the order to hold the aspirin. 2. Resident #64's record was reviewed on 01/12/11 at 10:25 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease and osteoarthritis. A physician's order,dated 12/15/10, indicated the resident had an abscessed lesion on the top of her right foot. The order indicated to apply Silvadene Cream (topical antibiotic) and a dressing daily for 10 days and then notify the physician of the healing progress. The MAR, dated 12/10, indicated the treatment to the abscess was not completed daily for the 10 days. The resident's nurses' notes lacked documentation to indicate the resident's physician had been notified as ordered, of the status of the area after the 10 days of treatment. During an interview on 01/12/11 at 10:50 a.m., the Residential Unit Manager indicated the treatment was not completed daily as ordered. She indicated the physician had not been notified as ordered. 3. Resident #48's record was reviewed on 01/11/11 at 1:46 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and Alzheimer's Disease. A) A physician's order, dated 10/19/10 indicated an order to discontinue the resident's 60 cc's (cubic centimeters) med pass (dietary supplement) three times a day.	R 241		

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R 241	Continued From page 9 The MAR, dated 11/10, indicated the resident received 2-cal HN (dietary supplement used as a therapeutic exchange for med pass), 60 cc's three times a day from 11/01/10 through 11/30/10. The MAR, dated 12/10, indicated the resident received 2-cal HN, 60 cc's three times a day from 12/01/10 through 12/31/10. The MAR, dated 01/11, indicated the resident received 2-cal HN, 60 cc's three times a day from 01/01/11 through 01/10/11. During an interview on 01/12/11 at 9 a.m., the Residential Unit Manager indicated the 2-cal HN was used for the Med Pass. She indicated it was not discontinued as ordered and the resident was still receiving the 2-cal HN three times a day. B) The physician's recapitulation orders, dated 01/11, indicated an order received 09/29/10 for accu-checks (blood sugar monitoring) to be completed daily at 6 a.m. and 4 p.m.. The order indicated the resident was on the following Humulin regular insulin sliding scale (insulin given per result of the blood sugar result): < (less than) 151= no insulin 151-200= 2 units of insulin 201-250= 4 units 251-300= 6 units 301-350= 8 units 351-400= 10 units > (over) 400= call the physician The MAR, dated 12/10, indicated the resident's blood sugar on 12/25/10 at 4 p.m. was 424, and 10 units of insulin was given. There was a lack of documentation on the 12/10	R 241		

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R 241	Continued From page 10 MAR and in the resident's record to indicate the resident's physician had been notified of the blood sugar over 400. There was a lack of documentation to indicate the physician had ordered 10 units of insulin to be given for the blood sugar of 424. The MAR, dated 01/11, indicated the resident's blood sugar on 01/05/11 at 4 p.m. was 267 and 4 units of Humulin regular insulin was given. During an interview on 01/11/11 at 1:50 p.m., the Residential Unit Manager indicated the resident should have received six units of insulin at 4 p.m. on 01/05/11. During an interview on 01/12/11 at 9:10 a.m., the Residential Unit Manager indicated the resident's physician had not been notified for the blood sugar over 400 on 12/25/10. She indicated the resident received 10 units of insulin for a blood sugar of 424. 4. Resident #81's record was reviewed on 01/12/11 at 9:35 a.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease and prostate cancer. The resident's physician's recapitulation orders, dated 12/10, indicated an order, dated 04/18/10, for CL-7 (herbal supplement), three tablets at bedtime daily. A nurses' note, dated 10/30/10 at 4:20 p.m., indicated the resident's family was notified the resident's CL-7 was needing refilled. A MAR, dated 11/10, indicated the CL-7 was not	R 241		

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R 241	Continued From page 11 given as ordered on 11/08/10 through 11/30/10 as ordered by the physician due to the medication was unavailable. A MAR, dated 12/10, indicated the CL-7 was not given as ordered by the physician on 12/01/10, 12/02/10, 12/04/10, 12/11/10, and 12/12/10, due to the medication was unavailable. There was a lack of documentation the resident's physician was aware the CL-7 had not been given and was unavailable from 11/01/10 through 12/13/10. During an interview on 01/12/11 at 10:10 a.m., the Residential Unit Manager indicated if the family does not bring in medications, the staff should order the medications from the back up pharmacy. She indicated the resident had not received the medication as ordered and the physician had not been notified of the resident not getting the medication until 12/13/10. She indicated the physician should have been notified earlier than 12/13/10.	R 241		
R 273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. This RULE is not met as evidenced by: Based on observation and interview, the facility failed to follow safe food handling standards related to undated, outdated, and unlabeled food stored refrigerators in 2 of 3 resident lounges (Ice Cream Lounge and Memory Care Unit Lounge).	R 273	R-273 Food and Nutritional Services 1. The Ice Cream Parlor refrigerator and Memory Care Unit refrigerator had all opened, undated and unlabeled food thrown out the day of the survey tour.	

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	155764	A. BUILDING _____ B. WING _____	01/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

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R 273	Continued From page 12 This had the potential to affect 10 of 10 residents who reside in the Memory Care Unit and 47 of 47 residents who reside in the residential facility. Findings include: During the environmental tour on 01/12/11 at 2:25 p.m. through 3 p.m. with the Maintenance Director, the following was observed: 1. The following was stored in the Ice Cream Lounge refrigerator: There was an unlabeled and undated open bottle of, "Juice Smoothy", with an expiration date of 11/15/10. There was an undated, unlabeled, and unidentifiable white substance in a jar. During an interview at the time of the observation, the Maintenance Director indicated maybe the substance was gravy. There was an opened, undated and unlabeled container of Philadelphia cream cheese with an expiration date of 11/10. There was a plastic container of an unidentified red substance with rice, which was unlabeled and undated. During an interview at the time of the observation, the Maintenance Director indicated it looked like Spanish Rice. There was a covered plastic bowl of lettuce, which was unlabeled and undated. 2. The following was stored in the Memory Care Unit lounge refrigerator: An unlabeled, undated box of chicken wings.	R 273	R 273 Continued 2. All residents have the potential to be effected by the alleged deficient practice. There were no negative outcomes noted. 3. Director of Dining Services will be in-serviced on proper labeling and dating procedures. 4. The DES or designee will monitor freezer and refrigerators in the Ice Cream Parlor and Memory Care Unit 5 days per week. Trends will be reported at the monthly QA meeting.	02/21/11

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R 273	Continued From page 13 During an interview at the time of the observation, Residential CNA #3 indicated it was her supper. She indicated she didn't have time to take it upstairs. An opened and loosely covered container of yogurt, which was undated and unlabeled. During an interview at the time of the observation, the Maintenance Director indicated it looked like someone had taken a spoonful out of the container. There was an undated and unlabeled thawed carton of Mighty Shake.	R 273		
R 297	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. This RULE is not met as evidenced by: Based on record review and interview, the facility failed to ensure a resident was provided with prescribed medications as ordered by the physician for 1 of 7 resident's reviewed for pharmaceutical services in a sample of 7. (resident #81) Findings include: Resident #81's record was reviewed on 01/12/11 at 9:35 a.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease and prostate cancer.	R 297	R-297 Pharmaceutical Services 1. Resident #81 had physician notified of medication not being given. There were no negative outcomes noted. 2. The current residents MAR's will be reviewed for the last 30 days. Proper follow up and notification will occur as needed. 3. The licensed staff will be in-serviced on the proper procedures when medication is not readily available. 4. The Unit Manager or designee will monitor the MAR's at least 5 days per week until 100% compliance is achieved and then twice per week for 3 months. Trends will be reported at the QA meeting.	02/21/11

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R 297	Continued From page 14 The resident's physician's recapitulation orders, dated 12/10, indicated an order, dated 04/18/10, for CL-7 (herbal supplement), three tablets at bedtime daily. A nurses' note, dated 10/30/10 at 4:20 p.m., indicated the resident's family was notified the resident's CL-7 was needing refilled. A Medication Administration Record (MAR), dated 11/10, indicated the CL-7 was not given as ordered on 11/08/10 through 11/30/10 as ordered by the physician due to the medication was unavailable. A MAR, dated 12/10, indicated the CL-7 was not given as ordered by the physician on 12/01/10, 12/02/10, 12/04/10, 12/11/10, and 12/12/10, due to the medication was unavailable. During an interview on 01/12/11 at 10:10 a.m., the Residential Unit Manager indicated if the family does not bring in medications, the staff should order the medications from the back up pharmacy.	R 297		
R 298	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping;	R 298	R-298 Pharmaceutical Services 1. Expired medication was discarded and refrigerators in medication rooms were cleaned with food discarded at the time of the survey.	

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R 298	Continued From page 15 (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. This RULE is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure medications were not expired for 1 of 5 resident's observed receiving their medications during two medication pass observations (resident #81) and failed to ensure medication storage practices were followed related to 3 of 3 medication refrigerators (1st floor, 2nd floor, and Memory Care Unit) were dirty and employee food stored in 1 of 3 medication refrigerators (1st floor). This had the potential to affect 55 of 57 residents who receive their medication from the facility. Findings include: 1. During a medication pass observation on 01/11/11 at 10:25 a.m., Residential LPN #1 prepared resident #81's medication, which included Procosa II (glucosamine supplement). Residential LPN #1 removed the two bottles of Procosa II from the medication cart. Both bottles of Procosa II indicated the medication expired on 09/10. During an interview at the time of the observation, Residential LPN #1 indicated he was unsure when the Procosa II was brought in for the resident from the family. He indicated the nurses are suppose to check expiration dates when they give the medications. Resident #81's record was reviewed on 01/12/11	R 298	R 298 Continued 2. The licensed staff will be in-serviced on the appropriate procedures for handling expired medications and keeping medication room refrigerators clean and without food. 3. The unit manager or designee will conduct daily audits for 3 weeks or until 100% compliance is obtained. Audits will then be conducted weekly with trends reported at monthly QA meetings.	02/21/11

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R 298	Continued From page 16 at 9:35 a.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease and prostate cancer. The physician's recapitulation orders, dated 12/10, indicated the glucosamine had been ordered on 08/14/10. The order indicated the resident was to receive two capsules of the glucosamine once a day. 2. During the environmental tour on 01/12/11 at 2:25 p.m. through 3 p.m. with the Maintenance Director, the following was observed in the First floor medication room: There was a brown spilled liquid on the door and bottom of the refrigerator. There was a plastic bag filled with grapes, a plastic bag filled with chips, a fruit cooler, a "Go Gert", and a bottle of water, which were all undated/unlabeled, and stored in the refrigerator. During an interview at the time of the observation, Residential LPN #1 indicated the night shift was suppose to clean the medication room. He indicated he did not know who the food belonged to. The Maintenance Director indicated it was not a resident's food. 3. During an observation of the medication refrigerator in the Memory Care Unit, on 01/12/10 at 9:20 a.m., with Residential LPN #2, there was a brown substance spilled on the top shelf of the medication refrigerator and the seal of the door had a large amount of black mold on it. During an interview at the time of the observation, Residential LPN #2 acknowledged the refrigerator was dirty.	R 298		

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R 304	Continued From page 17	R 304		
R 304	410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. This RULE is not met as evidenced by: Based on observation and interview, the facility failed to ensure a medication room and/or refrigerator was locked at all times, related to the Memory Care Unit nurses' station door being left open. There was an unlocked medication refrigerator located in the nurses' station. This had the potential to affect 10 of 10 residents who live on the unit, with the diagnoses of Alzheimer's Disease and/or dementia. Findings include: During an observation on 01/12/11 at 8:45 a.m. through 9:20 a.m., the door to the nurses' station in the Memory Care Unit was left open, and a floor fan was running and sitting in the doorway. The staff member on the unit was down the hall, in the dining room with some of the residents from the unit. During an observation on 01/12/11 at 9 a.m. to 9:15 a.m., there were two residents who walked up to the open door, attempted to walk into the nurses' station around the fan, then turned and walked down the hallway. During an observation of the unlocked refrigerator located in the nurses' station on 01/12/11 at 9:20	R 304	R-304 Pharmaceutical Services 1. The door was closed and the fan was moved during the time of the survey. 2. All residents have the potential to be effected by the alleged deficient practice. There were no negative outcomes noted during this occurrence. 3. Licensed staff will be in-serviced on securing the Memory Care nurses' office by consistently keeping the door locked. 4. The Unit Manager or designee will conduct rounds twice daily to ensure that the door is locked for 1 week or until 100% compliance is achieved. Door will be observed locked during daily rounds as part of ongoing QA process.	02/21/11

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R 304	Continued From page 18 a.m. with Residential LPN #2, there were three vials of insulin and a plastic container with a plastic lock on it, which contained medications. During an interview on 01/12/11 at 9:20 a.m., Residential LPN #2 indicated the door had been left open because of water on the carpeting. She indicated the residents on the unit could get into the nurses' station and could get into the refrigerator. She indicated the door was normally closed.	R 304		
R 349	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. This RULE is not met as evidenced by: Based on record review and interview, the facility failed to ensure residents' records were complete and accurate related to medication administration and changes in conditions for 3 of 7 resident's records reviewed in a sample of 7. (residents #46, #64, and #68) Findings include: 1. Resident #68's record was reviewed on 01/12/11 at 11:35 a.m. The resident's diagnoses included, but were not limited to, dementia and stroke.	R 349	R-349 Clinical Records 1. Residents #68, #64, and #46 were evaluated at the time of survey with no negative outcomes noted. 2. All residents have the potential to be affected by the alleged deficient practice. 3. The licensed staff will be in-serviced on appropriate documentation related to medication administration and changes in condition. 4. The Unit Manager or designee will review 24 hour report book and MAR's 5 times per week until 100% compliance is obtained. Once compliance is obtained reviews will be done 2 times per week. Trends will be brought to monthly QA meeting.	02/21/11

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R 349	Continued From page 19 A hospital, "History and Physical", dated 12/23/10, indicated, "...sent here from the assisted living due to coffee-ground emesis x (times) 2 this morning, also hemoccult-positive (test for blood) from the ED (Emergency Department)...Staff at the assisted living noted that the emesis appeared coffee-ground and was brought here by family...She was admitted under 23 hour observation..." The hospital return orders, dated 12/24/10, indicated, "...no...aspirin...until okay with (physician's name)..." There was a lack of documentation in the resident's record to indicate the resident had a coffee-ground emesis, went to the hospital, returned from the hospital, and the resident's status after returning from the hospital. During an interview on 01/11/11 at 11:10 a.m., the Residential Unit Manager indicated there was no documentation in the resident's record about the resident's condition. 2. Resident #64's record was reviewed on 01/12/11 at 10:25 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease and osteoarthritis. A physician's order, dated 12/15/10, indicated the resident had an abecessed lesion on the top of her right foot. The order indicated to apply Silvadene Cream (topical antibiotic) and a dressing daily for 10 days and then notify the physician of the healing progress. A, "Skin Circumstance" form indicated the resident's right foot was assessed each shift for 72 hours after the order was obtained.	R 349		

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R 349	Continued From page 20 There was a lack of documentation in the resident's record to indicate the right foot had been assessed after 12/17/10. During an interview on 01/12/11 at 10:50 a.m., the Residential Unit Manager indicated the resident's right foot assessment had not been documented since 12/17/10. She indicated the healing status should have been assessed and documented. 3. Resident #46's record was reviewed on 01/11/11 at 1:45 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and Alzheimer's Disease. The physician's recapitulation orders, dated 01/11, indicated an order received 09/29/10 for accu-cheeks (blood sugar monitoring) to be completed daily at 6 a.m. and 4 p.m.. The order indicated the resident was on the following Humulin regular insulin sliding scale (insulin given per result of the blood sugar result): < (less than) 151= no insulin 151-200= 2 units of insulin 201-250= 4 units 251-300= 6 units 301-350= 8 units 351-400= 10 units > (over) 400= call the physician The MAR, dated 01/11, indicated the resident's blood sugar at 4 p.m. on 01/03/11 was 235, 01/07/11 was 315, and 01/08/11 was 270. There was a lack of documentation to indicate how much insulin the resident received on these dates. During an interview on 01/11/11 at 1:50 p.m., the	R 349		

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R 349	Continued From page 21 Residential Unit Manager indicated the amount of insulin was not marked on the MAR.	R 349		